REPORT

OF THE

PLANNING COMMITTEE

ON

MENTAL HEALTH SERVICES

FOR

CHILDREN AND ADOLESCENTS

TO

THE MINISTER OF HEALTH

1984

Respectfully Submitted:
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EXECUTIVE'S SUMMARY

The Planning Committee on Mental Health Services for Children and Adolescents was formed at the request of the Minister in February, 1983. The committee members represented the professions of psychiatry, psychology, social work, nursing, and the Departments of Health, Social Services, including the William F. Roberts Hospital School, the Department of Education and the Department of Justice.

The major objective of the study was to make recommendations concerning the development of a comprehensive provincial system of mental health services for children and adolescents. The purpose was to provide input to the planning of mental health services for children and adolescents and not primarily to study the need for such services since it was felt that these had already been fairly well established.

The methodology used consisted of a review of the literature which was provided to the members; case studies which were carried out on children and adolescents, who had been seen by a number of service providers, to identify problems and propose remedies; studies and

reports by Barkow, 1983, Richman, 1983; documentation from the Departments of Social Services and Education plus a request for submissions from twenty-seven community agencies.

Some preliminary recommendations were requested by and provided to the Office of Government Reform in September, 1983 reflecting the thinking of the committee members at that time.

Twenty-two recommendations were made dealing with organizational changes; the need for coordination; the need to look at the gaps in legislation concerning children and adolescents; residential inpatient services; the definition of target populations, models, roles and functions needed to provide services; the need for early intervention and prevention, and the use of volunteers.

Need For Coordination

A major concern expressed by the committee members revolved around the need to develop some mechanisms to better coordinate services for children and adolescents so that existing professional and community resources could be better utilized. Nine of the 22 recommendations attempt to address this problem (1, 2, 3, 10, 11, 14, 15, 16, 18).

Inpatient Psychiatric Beds

The next most important area involves recommendations concerning the provision of a limited number of beds for children and adolescents in the psychiatric and pediatric units of each of the province's

regional hospitals. This means the availability of approximately two to five beds, depending on the size of the region. For the majority of cases, community mental health services are adequate to deal with the problems that children and adolescents may have, backed up by the availability of small group and therapeutic homes along with other existing community resources.

Need to Set Service Priorities

A recommendation was made to the effect that service priorities need to be established for children and adolescents, rather than continuing to operate on a demand model. This means that groups of children have to be identified and provided services based on their needs.

Role of the Volunteers

The role of voluntary agencies was also discussed with a recommendation that volunteers and professionals need to work together.

Finally, it must be pointed out that the recommendations made by the committee members do not represent the policies of their respective departments, but do represent the best consensus that could be reached by people representing a variety of constitutencies such as departments, disciplines, private practice and personal opinions based on years of experience.

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ACKNOWLEDGMENTS

On behalf of the members of the committee, I wish to thank the Minister and officials of the Department of Health who were responsible for this planning exercise.

I wish to express my appreciation for the participation and contribution of the members of the committee who brought with them a vast amount of knowledge and diversity of experience (cf. Appendix I).

The input and interest of volunteer organizations was most welcome and useful (cf. Appendix II).

Maurice Boulay, Psy.D., F.C.P.A.

INTRODUCTION

The Department of Health has been involved for over ten years in the reorganization and development of the province's mental health services to bring it in line with current thinking.

New Brunswick has kept pace with the trend which focuses on the community and de-emphasizes institutions in the treatment of persons suffering from mental and emotional disorders. Although many changes have taken place and many are continuing to take place, these have not been done without careful thought and study (Cushing 1968; Grunberg 1969; Holder-Franklin 1978; Mann 1979; The Southern New Brunswick Mental Health Planning Study, 1981).

Even though some recommendations were made concerning children and adolescent services in these studies, the focus was primarily on adult psychiatric services. Therefore, it is not surprising that most of the changes which have taken place within the New Brunswick Mental Health System have been directed at the adult service. This fact was recognized by those responsible for the Southern New Brunswick Mental Health Planning Study. Subsequently, the Department of Health decided to fund a study of Mental Health Services for Children and Adolescents in the province, (Richman 1980). This study was designed to provide epidemiologic data which would be useful for future planning of mental health services for children and adolescents. (cf. Appendix III).

In February, 1983 steps were taken to establish the Planning Committee on Mental Health Services for Children and Adolescents.

The major objective of the study was to determine the need to make recommendations concerning the development of a conprehensive provincial system of mental health services for children and adolescents (cf. Appendix II).

The Committee's mandate was to arrive at some conclusions as to what a comprehensive mental health system for children and adolescents entails. The focus was on the elements of the system necessary to deliver such services. The purpose was to plan mental health services, not primarily to study the need for such services since these had already been fairly well established (Barkow, 1983, CELDIC, 1970, Richman 1983). For this reason, the composition of the committee was vital since the recommendations would be based, in part, on the clinical, educational and administrative experiences of the committee members.

A literature search was done resulting in 334 abstracts which the committee members were asked to review. Subsequent to this, articles were obtained and assigned to each committee member.

Case studies were carried out on children and adolescents who had been seen by a number of service providers to identify problems and propose remedies (Appendix IV).

The study "Once More for Children" (Barkow, 1983) was reviewed and a meeting in Fredericton was arranged with Professor Barkow (cf. Appendix V).

A project carried out by Dr. Alex Richman provided background data for this study (cf. Appendix III).

Reports from the Child and Family Services Unit of the Department of Social Services dealing with children's needs, resources and a program design for treatment homes were looked at by the committee.

Documentation was provided from and a presentation made by officials from the Department of Education describing the services of the Special Education Services Branch.

A presentation was also made on the William F. Roberts Hospital School by Mr. Lorne McGuigan on the history and present status of the Hospital School.

Information was obtained on programs at the Izaak Walton Kilam Hospital for Children in Halifax and the Children's Psychiatric Institute in Ontario, since over the years a number of children and adolescents from New Brunswick have been provided with financial support to participate in these programs (Appendices VI & VII).

Letters were sent to twenty-seven agencies and institutions with seven of these replying to our request for feedback (cf. Appendices VIII, IX & X).

Committee meetings were held until April, 1984 and a draft report was distributed to the members during the summer.

It became evident during the first meeting that although the major professions involved in the provision of mental health services for children and adolescents were represented on the committee, not all of the departments were represented. For this reason, it was decided to ask the Departments of Education and Justice to appoint members to the committee. Representation on the committee was then made up of psychiatry, psychology, social work, nursing, the Department of Health, Social Services including the William F. Roberts Hospital School, the Department of Education and the Department of Justice.

Following the May 5, 1983 meeting of the Committee, the chairman was approached by a representative from the Office of Government Reform indicating that they were interested in the work of this Planning Committee. A representative from the Office of Government Reform was invited to attend the meeting of June 9, 1983. Although the initial request from the Office of Government Reform was to have this committee look at all children's services, this was not thought to be feasible within the constraints imposed at that time. The members of the committee felt that they would be able to provide a report on their thinking in the area of children and adolescent mental health services by September, 1983.

Finally, it must be emphasized that the recommendations made by the committee members do not represent the policies of their respective departments. However, the recommendations do represent the best consensus that could be reached by people representing a variety of constituencies such as departments, disciplines, private practice and personal opinions based on years of experience.

SUMMARY OF RECOMMENDATIONS

1. The goals and use of current resources must be changed and better coordinated before implementing organizational changes.

2. Regional interagency committees should be established for the coordination of mental health services to children and adolescents.

3. A provincial child and youth directorate should be established to lend support and integrate the work of these committees.

4. Each regional hospital must be given the resources necessary to make a minimum number of beds available for adolescents in the adult psychiatric unit and to establish a specialized program for them.

5. Each regional hospital must be given the resources necessary to admit children to the pediatric ward and to establish a specialized program for them.

6. Changes must be made to the hospital physical structure on the wards to control destructive behavior and to allow for the implementation of the treatment program.

7. Departments of psychiatry, nursing, psychology, social work, occupational therapy and recreation must be given the resources to establish programs and to work collaboratively in the treatment of children and adolescents who have been hospitalized.

8. Emergency services for children and adolescents must be made available in each of the regional hospitals.

9. In order to provide treatment in the least restrictive environment possible, small therapeutic homes should be established within each of the health regions and staffed by child and youth workers.

10. Local mental health, social services, educational and in some cases justice personnel must be involved in the admission treatment planning process for children referred to group and therapeutic homes.

11. Local mental health and education agencies need to identify the Department of Social Services contact persons to act as liaison program consultants to group and therapeutic homes staff.

12. Mobile resource teams travelling on an ongoing basis to work with people in residental and non-residential settings are needed.

13. Where feasible home treatment should be seen as a viable alternative to hospitalization.

14. An interdepartmental and adolescent service model be established and implemented in pilot regional offices and evaluated toward complete provincial implementation in 1985-86.

15. Each department develop an information package for other departmental services.

16. Have mental health and education personnel serve on Department of Social Services out-of-province committees.

17. Target population, models, roles and range of services be clearly identified when developing child and adolescents mental health services.

18. Roles and functions need to be continuously monitored with a view of providing a safety net for those children who fall through the gaps in the system.

19. Priorities for programs should be research based, realistic expectations are important it is not possible financially or because of lack of knowledge to be effective with all problems.

20. Structure should insure that adult and child services do not complete; where they do, services for children and adolescents lose out.

21. When programs are set-up as primary prevention they must have an evaluation component.

22. Voluntary agencies must be supported and encouraged along with establishing guidelines which would facilitate cooperation between volunteers and professionals such as links by involvements both on local boards and community activities.

DISCUSSION

Organizational Changes

In 1970, the Commission on Emotional and Learning Disorders in Children reported the results of a national study in this area and made 144 recommendations. These recommendations were grouped according to categories dealing with organization of services, personnel and research (CEIDIC, 1970). A brief review of these suggests that no more than two dozen of these recommendations have been more or less implemented in New Brunswick. This is not surprising since the CEIDIC report identified the lack of coordination and planning as a major problem. This, according to the report leads to a fragmentation of services, fragmentation of personnel functions and fragmentation of the child. They went on to say that, "Existing arrangements for delivery of services to the child in need fail to reflect the relatedness and interdependence of all helping services. In the variety of crises which occur in families, a range of services is necessary. To be effective, these services must not only be made available, they must be related one to the other." Barkow (1983) in referring to the CEIDIC report found it not at all out of date in reference to Nova Scotia's problems. It is evident from this we need to learn how to implement what we now know rather than forever seeking new knowledge leading us to do studies which reach the same conclusions as previous ones. This is not to deny that there is a place for research, but there surely must be a place for the application of the results of research.

This committee strongly advises against the temptation to look to an organizational "tour de force" to remedy the problems of gaps, overlapping, duplication, etc. with which change must be concerned. This position is supported by Richman (1983) who suggests that most of the focus in planning mental health services is on developing new administrative or managerial mechanisms, or making regulations more specific. He recommends that "organizational changes come after an attempt has been made to change the goals and use of current resources.

For example, when we plan services on the basis of diagnosis we may forget that children are referred, not on the basis of diagnosis but for such things as poor peer relationships, running away, fire setting and violent acts. Those who provide services need to look at other ways to provide services than the direct face-to-face mode of intervention. To do this the administrative structure must support and reward innovative modes of delivery of services. It may also be necessary to change structures, but it should not be done quickly. Attempts to improve existing structures are necessary. However, some reorganization is always necessary since there is no one universally accepted bureaucracy (Barkow, 1983). We recommend that:

1) The goals and use of current resources must be changed and better coordinated before implementing organizational changes.

Coordination

The need for coordination of services has been brought up in practically every study of services provided by public agencies.

Studies of interdepartmental services to children, whether carried out in this province or elsewhere, have consistently emphasized the lack of effective mechanisms to coordinate services to certain categories of youngsters with mental health disturbances. (Barkow, 1983, CELDIC, 1970, Holder-Franklin, 1978, Richman, 1983). This problem is brought up again by this Committee and supported by the submission from CMHA, CAMR, the NBTA and CRDC. They underline the fact that at present services to children are fragmented between Health, Education, Social Services and Justice and point to a need for a more coordinated and integrated approach. Better coordination between the voluntary agencies concerned is also needed. Failure to find a solution will result in these organizations continuing to work too much in isolation which will perpetuate duplication, rivalry and confusion. This is wasteful not only in dollar costs, but also in human resource. A major category in point is constituted by that large group of youngsters variously diagnosed as suffering from conduct disorder or delinquency. These children require and are given a great deal of services from a number of departments which commonly include Social Services, Justice, Education and Health. They constitute a large portion of the children served by Mental Health Clinics, the William F. Roberts Hospital School, the Youth Training Centre, School Guidance Services, and Personal Social Services. A small number (the tip of the iceberg) are sent out of province for treatment and management.

Common sense would seem to suggest that the services offered to these children could be more effective if given in a planned, coordinated manner which would enable a "synergistic" treatment impact

and consistent follow-up. As matters stand now, we simply tend to pass these cases around as crisis follows crisis.

This lack of coordination concerned our Committee no less than it has concerned others. It was, of course, this concern which prompted some direct studies by our Committee of particular children (representing larger groups) in order to explore a process which would enable better coordination of services and provide a clearer picture to senior administrative and planning levels of reorganizational and development priorities.

The model we used related an interdepartmental group (members of our Committee) of provincial <u>administrative</u> staff to interdepartmental regional groups of <u>service</u> staff. The regional groups were asked to audit representative "hard-to-service" children and report to the central group. The purpose of the audit was to identify problems of coordination and to propose remedies.

There have, of course, been previous interagency committees which have attempted the same thing. They have never lasted. Our experience suggests that if such regional initiatives are to succeed, they require linkage of and leadership from a central "authority" with a mandate to guide the orderly, integrated delivery and development of mental health services to children and adolescents. This would provide leadership in goal setting and relocation of resources with regional interagency input. Accordingly, we recommend:

2) The establishment of Regional interagency committees for the coordination of mental health services to children and adolescents.

3) The establishment of a provincial child and youth directorate which would lead, support and integrate the work of these committees.

Legislation

Concerns were brought up by a number of committee members, including the submission by the New Brunswick Teacher's Association, concerning jurisdictional responsibility which pointed out that the Schools' Act, the Juvenile Delinquency Act and the Child and Family Services Relations Act apply to age sixteen. There is inadequate provision for jurisdictional rights for the age span for sixteen and seventeen year olds. Without a legislative base it is difficult to accomplish integration and coordination of services and to establish an overall provincial policy for the delivery of services to children and adolescents. With this in mind we recommend:

4) The establishment of a legislative base responsible for all children and adolescent services for all persons to 19 years of age with provision to extend this to older persons under special circumstances.

Residential/Inpatient Services

The members of this committee have looked at inpatient services and have come to the conclusion that such services are completely unnecessary. The stigma of medical labelling and hospitalization, as well as the negative aspects of removing a child or adolescent from his own home, are real problems that require consideration. As well, there are fears about scapegoating children or adolescents, and

blaming them for problems whose real roots are either in their family or in a societal pathology. Finally, there is the belief that outpatient therapy or some social manipulation is adequate to deal with all emotional behavioural problems of children and adolescents, and that the numbers of these people who might ever require inpatient treatment are so small so as to make this a non-issue.

In spite of these beliefs, some sort of inpatient facilities for disturbed children and adolescents do exist in just about all metropolitan areas, and where they do not exist, there is strong pressure to develop them. These events occur because those individuals who are dealing with psychiatrically disturbed children and adolescents inevitably have occasion when they must deal with emergency situations when there is a real risk of danger occurring, or when the situation is so out of control that any further useful intervention is impossible to carry out. In these kinds of situations, children are often placed in highly inappropriate settings, or are sent long distances from their homes, entirely disrupting the therapeutic process. The types of situations which may require this type of intervention is when there is a risk of suicidal or homicidal behaviour, where there is a problem of intoxication, especially with hallucinogenic drugs, when judgement is impaired and with functional psychoses. Even the most caring and best supported community workers in therapeutic group homes or foster homes, or parents themselves, are unable to cope with these kinds of situations and try desperately to find some safe place where control can be regained over the situation.

In addition, some youth with chronic problems who may be involved in ongoing programs, may become out of control or no longer amenable to the planned interventions because of an unexpected change in their environment which leads to a crisis.

Occasionally there are complex psychological problems such as infantile autism or other pervasive developmental disorders, behavioural problems superimposed on underlying neurological disorders, or mental retardation, which require an intensive neurological, psychological, and social evaluation that cannot readily be done on an outpatient basis.

Finally, there may be court ordered evaluations which also cannot be carried out in the community.

If it is concluded from the above reasons that there is a real need for some inpatient facilities for serving children and youth with mental health problems, the next question is what kind of inpatient settings would be appropriate for New Brunswick. The older style of residential treatment centre that was popular over the last two or three decades seems currently in disrepute. A large, centralized live-in institution with educational, therapeutic, as well as residential facilities, has been the norm in some centres but this is being found to be not particularly cost-effective for the kinds of patients who become residents, and to be frequently used as placement, rather than treatment centers, for hard to manage children who have exhausted the community's ability to put up with them. (Richman, 1983, Barker, 1982).

Current thinking seems clearly to be moving in the direction of establishing a small therapeutic living situation in group or foster homes where children can be kept in their own community, where families can continue to be involved in ongoing therapy programs, and where foster parents or group home parents can be given the support that they would require for managing children with troublesome behaviour.

For children who require continuous observation by professional staff, the obvious alternative would be in the regional hospital. Because there is an inadequate population base to support the development of specialized units for these children, it would be advisabel for them to be integrated somehow into the other units already in the regional hospitals. It is estimated that one bed per 50,000 people would be required for adolescents and one per 100,000 for pre-adolescents, so it would clearly not make any sense to try to set up even small, five or six bed units, specifically to deal with adolescents who require inpatient treatment.

What seems to be done in most settings, including some New Brunswick regional hospitals, is to integrate adolescents who need to be in hospital into the adult Psychiatric Unit, and to establish a specialized program for them; and to admit younger children to the Pediatric ward with specific intervention by mental health staff when it is needed.

Certain specific guidelines should be adopted. It should be clear that these admissions would be for acute and short-stay type of problems requiring perhaps a few weeks at the most within the

hospital. It should be realized that such admission practices will have an effect on the hospital as a whole, and it must be clear to staff, patients, and the hospital what the treatment philosophy is. There must be clearly defined programs to meet the needs of this younger psychiatric population, and especially, trained nursing staff who know how to deal with this age group with these kinds of problems, how to set limits, control acting out behaviour, and deal therapeutically with these developmental tasks of adolescents. In addition there would have to be psychiatrists on staff at the hospital who have the ability and inclination to take responsibility for these children. There would also have to be a physical structure on the wards which is adequate both to control disruptive behaviour, and which will allow for the implementation of the treatment program. Not only nurses, but departments of psychology, social work, occupational therapy, and recreation must also be prepared to establish programs and work collaboratively in the treatment of these children.

Most important, and perhaps most difficult, is to have a positive attitude on the part of the hospital staff who will be touched by such admissions. Many staff on an adult psychiatric unit will feel that the intrusion of adolescents, especially those whose behaviour is out of control, will lead to disruption of the ward, and generally be disturbing to the older patients. Similarly, attitudes on pediatric wards of rejecting children who are "not really sick" must be dealt with, as well as the realities of the amount of time and energy that these kinds of children can require from the nursing staff.

It may be that New Brunswick has a certain advantage compared to other more financially endowed provinces in that care-givers here have had to be more self-reliant and have generally expected less from experts and specialists. They have generally learned to deal with problems by using what facilities were available, even if that would not be the way things were done in Toronto or Halifax. For that reason, rather than there being any resistance to the implementation of these kinds of ideas, there may very well be some delight in a recognition that providing some programs which have already been created does require extra support in terms of training and resources.

Therefore, we recommend that:

5) Each regional hospital must be given the resources necessary to make a minimum number of beds available for adolescents in the adult psychiatric unit and to establish a specialized program for them.

6) Each regional hospital must be given the resources necessary to admit children to the pediatric ward and to establish a specialized program for them.

7) Changes must be made to the hospital's physical structure on the wards to control disruptive behaviour and to allow for the implementation of the treatment program.

8) Departments of psychiatry, nursing, psychology, social work, occupational therapy and recreation must be given the resources to establish programs and work coolaboratively in the treatment of children and adolescents who have been hospitalized.

9) Emergency services for children and adolescents must be made available in each of the regional hospitals.

This committee has not specifically addressed the question of partial hospitalization or day treatment programs, mainly because of some doubts as to how and where these could best be established. It may very well be that a partial hospitalization program would be most indicated for those youth who require a period of hospitalization as well, and that the resources of the hospital could be well brought into use in a day therapy approach. On the other hand, it might make more sense for such a program to be physically, as well as philosophically, separated from the hospital in a different kind of community setting such as a community health centre, YMCA and so forth. There are too many questions in this area to be able to come to any conclusions about what would be the best approach to take except to affirm that such programs would certainly be required for those youth who do need ongoing and moderately intensive treatment. Many of these children could also be involved in therapeutic group homes, foster homes and perhaps also in some special educational facilities where their behavioural problems could be best controlled. However, we must be aware of the difference between residential <u>placement</u> and residential <u>treatment</u>.

The Department of Social Services is committed to a model of community based residential services for those children who require specialized or therapeutic settings. This means that children are expected to be served, as much as possible, in small, home-like environments in residential neighourhoods and integrated in local

schools, leisure activities and other community agencies. Because a community based system is, by nature, decentralized, its effective operation is dependent on access to local resources and expertise.

At the present time, there is no commitment from health agencies to recognize the special support needs of group and therapeutic homes across the province.

In view of the above, this committee makes the following recommendations:

10) In order to provide treatment in the least restrictive environment possible, small therapeutic homes should be established within each of the health regions and staffed by child and youth workers.

11) Local Mental Health and Education personnel must be involved in the admission/treatment planning process for children referred to group and therapeutic homes.

12) Local Mental Health and Education agencies need to identify to the Department of Social Services contact persons to act as liaison/program consultants to group and therapeutic home staff.

13) Mobile resource teams travelling on an ongoing basis to work with people in residential and non-residential settings are needed.

14) Where feasible, home treatment should be seen as a viable alternative to hospitalization.

Target Populations, Models, Roles and Functions

It is not enough to want to coordinate services but we need to know what to coordinate, how to coordinate, who coordinates and what the mandate is to carry out this coordination function. There is a definite need for role definition of the various agencies. It was concluded that children and adolescents are not part of a treatment network. Each agency attempts to deal with each case, often keeping it longer than necessary before referring to another agency. At this point it is often seen as a failure so that the referring agency is resistant to taking that child or adolescent back at a later date. This would be less likely to happen if each agency was seen as part of a service network providing treatment on an interactional basis with other member agencies. Formal agreements between agencies are needed. These should specify target populations, services provided, quotas and priorities.

The present way of delivering child and adolescent services has resulted in interventions which are often inconsistent and uncoordinated with professionals who often lack understanding and appreciation of the philosophy and methods of intervention of the major service providers. There is also a need for sharing of information about resources which are available. With these points in mind we make the following recommendations:

15) Each department develop an information package for other departmental services and these packages be delivered by appropriate departmental training divisions.

16) Have Mental Health and Education personnel serve on Department of Social Services "out-of-province" committees. (Completed).

17) "An interdepartmental children and adolescent service" model be established and be implemented in pilot regional offices and evaluated towards complete provincial implementation in 1985-86.

In his discussion on clinic roles and functions, Richman (1980) suggests that we need to determine which clinical services (assessment, diagnosis, consultation, intervention and continuation of treatment) are to be emphasized. He goes on to say that "currently, they are responding to a wide variety of problems many of which cannot be distinguished from the kinds of problems seen within family service agencies, school psychoeducational services or child development programs." It would seem from this that our mental health clinics provide open ended services in response to whatever demands are made upon them. This may have been possible during the days that government spending could be adjusted accordingly each year but in view of shrinking budgets is no longer realistic. To a certain extent, this has already occurred in mental health services with the identification of primary, secondary and tertiary prevention components of these services. This has resulted in a shifting of resources from secondary prevention to the other two components. However, it is still necessary to go beyond the definition of broad philosophical goals and to translate these into specific goals and objectives which are in some way measurable. We agree with "Mental Health New Brunswick" and CAMR who state that services should be centered or focused on the child and adolescent which in turn requires sensitivity to the family and its environment. Within this context

programs and the range of clinical interventions can be developed for target groups. We recommend that:

18) Target populations, models, roles and range of services be clearly identified when developing child and adolescent mental health services.

19) Roles and functions need to be continuously monitored with a view of providing a "safety" net for those children who fall through the gaps in the system.

20) Priorities for programs should be research based. Realistic expectations are important. It is not possible financially or because of lack of knowledge to be effective with all problems.

21) Structures should ensure that adult and child services do not compete. Where they do, services to children and adolescents lose out.

Early Intervention/Prevention

Both health promotion and active treatment programs are necessary and should not compete. Programs that have intrinsic value do not need to be justified as prevention. It is important to note that when we refer to prevention we are addressing all levels of prevention defined as follows:

a) Primary prevention aims at reducing the incidence of new cases of disorders, disabilities and dysfunctions the population.

b) Secondary prevention attempts to reduce the numbers of existing cases of disorders or dysfunctions.

c) Tertiary prevention aims at reducing the harmful effects resulting from established disorder or dysfunction.

Early intervention programs are often put in place with the belief that these will prevent the development of disorders in high risk children. Early intervention programs are also initiated for children who already have been diagnosed as disabled. Therefore, early intervention programs may cut across primary, secondary and teritary prevention.

Having given the definition for each of the prevention categories we wish to focus on primary prevention and recommend that:

22) When programs are set up as primary prevention they must have an evaluation component.

Volunteers

The role of volunteer agencies in providing mental health services to children and adolescents must be seen as essential if these services are to be complete as well as effective. Many of these volunteer groups provide on-site, i.e., in the home, support and encouragement. This form of work is usually impossible for clinic personnel due to workloads and numbers of staff. Thus, by working cooperatively with these other agencies the therapy begun at the clinic can be re-enforced in the home setting on a more regular basis than a weekly visit to a clinic could provide. Also, parents

frequently need support from others in their similar situation and the volunteer groups provide this form of sharing. Many of these groups may also work towards changing the necessary legislation required to make needed services available. Without expressing the "needs" of these children, new services would not be seen as essential.

Volunteer groups such as the Canadian Mental Health Association and the Canadian Association for the Mentally Retarded play a vital role in educating the public about available services and about what is mental health. It has been noted by our committee that the "image" of mental health can often interfere with people seeking needed treatment. More public relation work and education could help reduce the negative stigma people in society now hold of "mental health services". It would be hoped that a reduction of this stigma would encourage people to seek help sooner, thus reducing the length of treatment necessary.

Those therapists already involved with volunteer agencies such as the Canadian Association for the Mentally Retarded; Brothers/Big Sisters; Association for Learning Disabilities; Groups for Single and Remarried Parents; Groups for Abusing Parents; and the Red Cross Society know of the invaluable contribution these groups make to stabilizing home situations. Often by involving such groups as part of a treatment plan, children are able to remain in their homes and institutionalization is not required. With these support systems in use the parents, school and community are able to cope with disturbed children without resorting to separating parents and children through hosptialization, etc.

The involvement of volunteer agencies in providing mental health services should be strongly supported and encouraged. More complete use of these services could enable the professional workers to meet the needs of greater numbers of children without excessive increases in funding. The role of these groups is essential if complete services are to be provided without vast increases in funding for mental health services. More cooperation between volunteers and professionals should be implemented through links by involvement on local boards and community activities.

This committee recommends that:

23) Voluntary agencies be supported and encouraged along with establishing guidelines which would facilitate cooperation between volunteers and professionals such as links by involvement on local boards and community activities.

Conclusion

We have seen that the single most consistent observation made by the members of the committee relates to the fragmentation of services which creates significant gaps in the delivery of mental health services to children. Remedies have been proposed but with the caution that we must be reasonably assured that the proposed "cure" is not worse than the disease. Having said this, however, the need for organizational changes was still felt and recommendations were made to correct deficiencies and to create new ways of delivering services.

The desirabili'y of treating children within the community outside of an institutional setting was reaffirmed. A plan was made to the effect that services to children and adolescents must be "child and adolescent focused". This should dictate the kinds of services needed and the resources, human and physical, required to provide these services along with the changes necessary in our thinking to carry this out.

Appendix I

PLANNING COMMITTEE MEMBERSHIP

on

MENTAL HEALTH SERVICES

for

CHILDREN AND ADOLESCENTS

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Appendix II

PLANNING COMMITTEE
ON MENTAL HEALTH SERVICES
FOR CHILDREN AND ADOLESCENTS

Preamble

Services for children and adolescents are presently provided through specialized teams in mental health clinics located in Moncton, Saint John and Fredericton. Edmundston, Campbellton and Bathurst regions provide services through their generalist teams.

Inpatient services are provided through the William F. Roberts Hospital School in Saint John. None of the general hospitals provide inpatient services for this population.

To date, no studies have been done by the Department of Health to plan for child and adolescent mental health services in the province of New Brunswick.

Terms of Reference

General

To determine the need and make recommendations concerning the development of a comprehensive provincial system of mental health services for children and adolescents.

Target Population

Children and adolescents to age 19 who suffer from a mental disorder or are at risk for the development of a mental and emotional disorder.

Principles

Services to children and adolescents should be governed by the same standards of quality in effect for the treatment of the adult psychiatric population.

Treatment must be provided in the least restrictive environment and as close as possible to the child's or adolescent's home.

Child and adolescent mental health services should be integrated with general health and community services.

Children and adolescents should be followed through the system to ensure that treatment and support needs are met.

Specific Objectives

To determine the extent of the need for child and adolescent mental health services.

To identify the type of services which can be developed.

To consult with those agencies, organizations, individuals and others associated with the delivery of services for youth.

To determine the need for residential and/or institutional services.

To determine the need for home and community based services.

To identify staff required for the delivery of children and adolescent services.

To identify staff training needs.

To comment on the effect of existing legislation affecting the care of children and adolescents.

Length of Study

The committee should have a preliminary report ready by October 1, 1983 and have its work completed by April 1, 1984.

Appendix III

A BACKGROUND FOR PLANNING

Preamble

This is a summary of the results of a project which was carried out by Dr. Alex Richman and funded by Mental Health Services, New Brunswick Department of Health and assisted by a National Health Research and Development Program Award #6603-1115-48. A copy of the full report was distributed to the committee members and is available on request from the Mental Health Services head office.

Purpose of the Study

To provide the information necessary for the planning and evaluation of mental health services to children with special emphasis on the delivery and clinical aspects of the services.

The Study

The study population consisted of 6,290 children and adolescents under the age of 16 who were seen in public facilities during the 1975-1980 period. Files were anonymized then merged. A number of statistical tables were produced and are available in the full report.

MAJOR FINDINGS

Facility of First Contact

The majority of patients were first seen in the mental health clinics which made up 90% of the study population. Eighty-seven point

eight percent (87.8%) of the children were seen only within the mental health clinics and had no contact reported with the general hospitals or the mental hospital.

Diagnosis

The most frequent diagnoses were for behaviour disorders of childhood followed by mental retardation. A large number of children were seen for non-psychiatric reasons.

Clinical Course of Care

Clinical abstracts submitted for one third of the new patients registered during a twelve month period from July 1, 1978 were reviewed for all of the New Brunswick Mental Health Clinics. Boys made up two thirds of the referrals with the highest proportion of referrals in the 8-9 year and 12-13 year olds. Seventy-one percent (71%) of the referrals were to the clinics in Saint John, Moncton and Fredericton.

Referral Source

The principal referral source was a physician (38.4%) followed by the family (26.7%), with education (14.0%), Social Services (10.6%), legal and other (6%).

Reason for Referral

The main reasons for referral were assessment (24.4%), school problems (15.2%), behavioural problems at home (10.6%), learning and developmental problems (8.3%), adjustment relationship and management problems (9.0%), with the rest distributed relatively evenly among

twelve other categories, one-fourth of the children were preschool (25.4%).

Professional Staff

The professional staff most likely to see a child first was a psychologist (38.2%) followed by a social worker (24.9%), a psychometrist (15%), a psychiatrist (10.7%) and nurses (9.9%). After the initial inerview, an additional 20% of cases was seen by psychologists totalling (58.6%) with a social worker seeing an additional 4.5%, psychiatrists an additional 8.3%. The treatment modality most frequently used was assessment (71.9%), counselling (33.5%), individual therapy (8.6%) and family therapy (7%), 34.8% of the children were seen only once.

Accessibility

Services provided by mental health clinics to children and adolescents seem to be accessible. However, questions are raised concerning the severity of the disorders which are treated at the mental health clinics. It is important to look at the possibility that a significant number of children could be easily or effectively treated by other agencies in the community. Presently, mental health clinics are responding to a wide variety of problems many of which cannot be distinguished by the kinds of problems seen within family service agencies, schools, psycho-educational services or child development programs.

Roles and Functions

It was not possible to identify the service delivery model which the clinics were using in this survey. Frequently, the practitioners seem to operate in a manner similar to solo practitioners who are sharing the same physical accommodations but not the funtional skills. It was also difficult to determine how the work of the clinic was coordinated with that of other workers and agencies in the community and how responsibilities were determined. This raises the question as to what is the most appropriate role and setting for "mental health clinic services",... health, education or social service setting?

Presently, clinics respond to individual cases as they appear one by one instead of having clinical programs for target groups which are differentiated by severity and need for continuing long term contact.

Clinical Programming

The following should be considered in planning clinical programs.

1. Lack of defined roles and responsibility of mental health clinic services, and need for more coordinated relationships with other parts of the health, education and social services systems.

2. Difficulties in the coordination and continuity of services for individual cases, between the services and staff of an individual clinic and between different agencies.

3. Absence of a systematic mechanism for planning and organizing services at the regional level in relation to other agencies and facilities.

4. Targeting of specific clinical groups for priority for specifying the indication for, and nature of, inteventions and the mechanisms for coordination and follow-up.

Inpatient Psychiatric Treatment

Admissions to hospitals should not be used because community facilities are inadequate. That is, the hospitals should not be used as a "substitute home".

There is a need to differentiate between residential treatment and residential placement.

An important point noted in this report is that more services do not necessarily solve the problem and for the multi-problem child, they probably add to it.

Antisocial Adolescents

No effective treatment modality seems to be available for antisocial adolescents and the question is raised whether this might be due to the perception of antisocial behaviour as a sickness rather than lack of socialization.

Continuity and Follow-Up

Although assessments appear to be the primary service provided by the mental health clinics, there seems to be a weakness in feedback of the results of the assessment and follow-up.

Adolescents who are discharged from either of the two provincial psychiatric hospitals should be identified as a target group for programming.

Conclusion

The general conclusions of this study were that there was no evidence of unmet needs for residential or inpatient treatment facilities. There is a need to allocate current resources in relation to the kinds of problems being seen and the kinds of services being provided; to develop a more specific statement of role and function; to provide consultation and inservice training to outside agencies in order to improve their ability to deal with children and adolescents, rather then to have the mental health clinic faced with the general responsibility of most behavioural and developmental problems in children and young people.

Appendix IV

CASE STUDIES

Because with the more difficult case a number of government agencies may be involved, the committee members decided to carry out interdepartmental case audits. The following case studies may help towards a better appreciation of the problems encountered.

Case Study No. 1

This is the case of a fifteen year old boy named John[1]. He's been involved with various agencies throughout his life, including the Fredericton Mental Health Clinic. He was referred to the Fredericton clinic in March, 1982, while in the Youth Training Center (YTC). John has had a difficult childhood, his parents separated and his mother abused alcohol. The father is described as being psychopathic and also abuses drugs and alcohol. He is a small child for his age and has difficulty in school. His parents separated when he was four and he then moved back and forth between his mother and father. He was expelled from kindergarten after his first day because of behavior problems. He repeated Grade 1 and was placed on tranquilizers in Grade 2. At age six, he burned a barn and stole $1,500. Occasionally, he would run away from home and become heavily involved in stealing and shoplifting.

He arrived in Fredericton from British Columbia in October, 1981. His sister took care of him since his mother was in no condition to take care of him because of her drinking. He was

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[1] John is a fictitious name to protect the identity of the client.

caught shoplifting in December, which resulted in his placement at the YTC. He was released from the Centre in August, 1982. In December, 1982, he was severely beaten by his mother. Following this incident, she asked for help from Social Services. The family was provided with family therapy and John was placed in a Special Education class. John is now a more controlled and passive youth but still has problems with his schooling. He gets very bored in class and with his studies. Motivation is very low. He has difficulty coping in a normal school system. His verbal skills are normal and his physical activity is normal. The mother is not familiar with John's "Special Education Program and might even be intimidated by it".

In evaluating this case, the participants discussed whether other methods could have been used to help John and his family. It was noted that problem solving was focused on John, whereas better results might have been obtained if intervention had been aimed at the family. There should have been more communication among the parent, social workers, the school, the YTC and the clinic. It was noted that both parents had on several occasions presented to the emergency department due to intoxication or drug abuse. This raised the question as to the timing of the intervention with obviously high risk families and children. The same thing happens when parents are involved with the law, children are usually ignored. The adequacy of the school system's ability to deal with children like John was questioned.

Of particular importance in this case was the lack of long term planning for John, especially since the placement order will terminate when he reaches 16 years of age and his mother's lack of motivation to continue treatment.

Case Study No. 2

Billy, a nine year old boy, was first referred to the clinic at the age of three for speech therapy. He was found to be head-banging, rigid, sitting on the floor with no response. Billy responded better with males. He was diagnosed as being autistic and it was recommended that he be placed in day care and that the parents go for intensive therapy. Billy's father reluctantly agreed to enter therapy.

At four, Billy still had a speech problem but was doing better. He was then put in day care. During that time, he was still going to the clinic. When Billy turned six, his mother was very worried about what would happen when he started school. At this time, he was placed on medication so that he would be able to cope with other people. He was allowed to attend school for half days provided he was accompanied by a tutor. On the recommendation of his family physician, he was sent for a psychological evaluation at the IWK, in Halifax, in 1980. They confirmed that he was autistic. He was evaluated twice at the Killam and both he and the mother spent some time there during the summer on a special program.

In April, 1981, he was well enough to go to school full time but by June, 1981, there wasn't any support person available for him and he was sent home.

In September, 1981, he went to the children's hospital in Halifax and they recommended that he go to a speech therapist.

In May, Billy was really improving and by June, he had changed enough that he was going to school. In September, he went to a

special class and was very happy about it.

Questions raised about this case are: What happened in Halifax that could not happen here? If it is not done here, could we develop it? What did it cost to send Billy to IWK and who paid?

A program description was obtained from the IWK Hospital for Children in Halifax giving information on the services which had been provided to Billy and his mother. The question on the cost of the interventions was not clear from the documentation available but can be estimated on the basis of the ward cost while they were attending the program which was $429 per day for at least seven days. The child was also followed up by a physician who saw the child on a daily basis while attending the program. Program material was distributed and discussed. The general conclusion was that there does not exist an identical program within the province, but there are equivalent interventions available. It is yet to be determined whether such a program needs to be developed in the province or whether programs which already exist within the province do not have as high a profile as the IWK, people generally make the assumption that programs which are available there are superior to any that exist, at least within the province of New Brunswick. However, it is a fact that the general practitioner can refer children directly to this program and the treatment there is presumably funded by this province without knowing whether an equivalent service is available in New Brunswick. There seems to be a need for better control over such referrals. There is also a need to communicate with IWK to find out from them the number of children which are referred to these services on a yearly basis.

The problem of determining the number of children receiving

services out-of-province and who pays for these services is reflected generally. For example, the Department of Education was aware funding was provided for four hearing impaired children in a facility in the province of Quebec, but later discovered that there was a total of twelve children in this program. The program which was described from the IWK suggests that it could very easily be carried out on an outpatient and/or day therapy basis, probably at considerably less cost. This whole area is another glaring example of the lack of a coordinated treatment network.

Conclusion

These and other case studies which were carried out in Campbellton and Saint John point to the same problems including sending children out-of-province which is done more in Saint John than anywhere else in the province. However, children are sent elsewhere in the first place because health services do not appear to deal well with children who have severe behavioral, sociopathic problems. In other words, physical violence, impulsive behavior, chronic runaways and fire setting are important variables requiring special attention.

Information was obtained for the program at IWK (Appendix III) Landmark School and Children's Psychiatric Research Institute (Appendix V).

As was stated earlier, many aspects of the IWK program could be implemented in our regions. For example, the expertise exists within most regions to develop a behavior therapy program similar to IWK and, in fact, would be more appropriate here because the child would be obtaining this service close to his/her home. It would facilitate incorporating what was learned with the child's environment and permit

better follow-through.

The Children's Psychiatric Research Institute offers residential treatment for all conditions, problems or behavior problems for children and adolescents to age 18 years. The program is carried out by staff from a wide range of disciplines including child care workers and recreational staff. The content of the program was not described although the committee members who had been involved with children sent to CPRI felt it was successful.

In looking at the Landmark School, other than the fact that staffing at this school has a ratio of one staff to three children, it appears to be the dedication and the skill of the staff which ensures success. It underlines the need for alternative learning environments with a therapeutic emphasis, with very carefully selected, dedicated, and well trained staff. The children attending these programs are usually learning disabled with no severe emotional problems.

A conclusion reached as a result of the interdepartmental case audits is that children and adolescents are not part of a treatment network. Each agency tries to deal with each case and often keeps them longer than necessary before referring them to another agency. At this point, they are often seen as failures so that the referring agency will be resistant to taking that child or adolescent back at a later date. This would not happen if each agency was seen as part of a treatment network providing treatment on an interactional basis with other member agencies. This would facilitate the development of the case manager concept and interdepartmental case auditing.

Appendix V

ONCE MORE FOR CHILDREN

A special meeting was held on February 9 and 10, 1984 for the purpose of reviewing the Nova Scotia study, "Once More for Children", (Barkow, 1983). The study took two years to complete and the state of professional rivalry was high. The Metropolitan Mental Health Planning Board chose an advisory group representing the major disciplnes in the Departments of Social Services and Health.

The study was funded by the Department of Health. In the space of two years meetings were held regularly, interim reports were written, priorities were set, recommendations were drafted and the final report was completed. Most of the research turned out to be evaluation research. The field data that was used had many flaws and were more self-serving devices used by agencies for budget purposes.

Professor Barkow felt that if he had addressed himself to needs, he would have been wasting his time. The vast majority of reports dealing with needs have had no impact. The problem was not what was needed, but whether the political organization and political process felt there was a need. All of the talent and labour devoted to these studies had little impact because they did not address the problem of how you create the climate to implement recommendations. Proposed changes should be directed at better utilization of resources at hand rather than changes which will require new and expensive resources.

With respect to data collection, it would be desirable to collect data across departments. However, there are legal problems with this in relation to confidentiality of information.

In order to plan children and adolescents services properly, a lot of input is necessary from people who are knowledgeable about the research literature. An expert in psychiatric epidemiology is needed to apply that literature to existing problems. The data which is most sparse is that dealing with treatment.

Research priority has to be given to children's mental health services. Knowledgeable people need to be brought in to conduct continuing education and give a seminar in research. A cabinet level committee including Health, Justice, Social Services and Education is needed to meet regularly and decide policy on issues affecting both children and adolescents.

Family Court judges are likely to be the strongest supporters for children services.

The problem of professional rivalry should be taken seriously. Psychiatrists feel that their identity is threatened. Disciplinary tensions between psychologists and social workers is much less. Obtaining social workers with clinical skills will be a problem in the future.

Stigma is a major problem, in fact it is ten times greater than what most professionals think. If a variety of services are offered in a central building, there is no special stigma attached to coming out of a Mental Health Clinic.

Separate Health and Social Services Departments make it easy to scapegoat one or the other. Senior figures at the Deputy Minister level have a tendency towards rivalry.

A major reason why bureaucracy in government does not work is there are no reward systems and incentives. The problem arises because we do not set down and design productivity incentives.

Another problem is staff shortages, problems with recruitment arises because a critical mass for professionals is required. It is not a good idea to have to transport children very far away from home. If you have travelling clinics, you have people spending half their time on the road. There are no community support services in rural areas. Rural areas require different recommendations than the city. "Work on support services." A neglected group in this study is the GP's.

GP's have to be educated to improve the level of care that the family practitioner provides and to increase his/her ability to spot child and adolescent mental health problems. Programs that acquaint the GP's with child and adolescent mental health services need to be encouraged.

In discussing the multi-problem family, it was suggested that somehow the transmission of problems from one generation to another must be broken. For the impossible child, the answer is not to send them from one foster home to another.

In regards to primary and tertiary prevention we should aim at the high risk groups. Prevention should be based on solid research and we should use the term prevention only when we have to. If we are going to talk about primary prevention, we must keep in mind we do not know what prevents what. These should be developed as research

projects. If it is not a research project, you have nothing to show that the programs are working. Evaluate in terms of preventing some recognizable problem. If clinicians are doing prevention, there has to be a limit, otherwise they may neglect their clinical work.

Statistics - In looking at statistical information we need to take notes on the problems with the data. We can use bad data to pinpoint areas where programs are needed.

Schools - We should recommend that mental health services be dispensed from the schools. Mental Health personnel can operate in the schools providing services to students and acting as consultants. This is not a recommendation without problems. Problems may arise between the Department of Education and the Department of Health. The difference between primary and secondary is a useful resource. If we have to label the services provided to schools, we can call these secondary prevention. If we are going to dispense mental health services from the schools, these should not just be mental health services. By providing mental health services along with other general health services, we avoid the stigma associated with mental health.

Rural areas are de-populating and urban areas increasing. In particular older people stay put and the younger people move to urban areas. We need to obtain an age and sex breakdown from the clinics and to take a look at basic demographics to see if each age group is proportionately represented.

Collect Standardized Data - Suggest that services be coded, document variation, distribution of load, what kind of professional does the initial contact, how much time is spent and how many weeks the case is open. If we are trying to impose a uniform system, we have to use a standard form. It is a good idea to get local doctors involved as part of the system. Data from private practitioners reveals that they do much psychosocial work. If we ignore our GP's, we are ignoring the people who provide much of the service to adolescents.

Administration - If we do not have to reorganize, then don't. Reorganization is disruptive. Bureaucracy means major problems, automatic fragmentation. Organize by function and take a look at the individual using the service. Some reorganization will always have to be done, there is no set bureaucracy. We need to identify the continuing crises. Integration at all levels of bureaucracy is required. People tend to defend their territory. Only deal with matters that affect more than one department.

Local Committee - The local committee would have a working executive chosen from the general membership by the membership. Include a GP, pediatrician or child psychologist. The working membership would have to handle problems of coordination. Local committees are the lobbies - official links to cabinet. A local committee should do a resource survey, then talk about the most desperate need and build from there.

A regional approach may be something else to look at. Include the option of building a secure place for youth. Get three provinces to agree. A regional residential treatment facility would provide security for youth as well as a home.

Therapeutic Group Home - Cannot evaluate how efficient they are.

Specialized Foster Care - Train foster parents and give them back-up. This is politically difficult to establish - good for low populated areas. Treatment centres - less expensive - have an added educational component. Crisis Intervention Centres and Drop-In Centres helpful.

Try to build multi-service centres. If they are not in the same building have them in close proximity. It is difficult to coordinate services because of this. Get people involved to overcome the bureaucratic system.

Health centres would require an advisory board with local representation. The problem of autonomy will have to be faced. Maintain tight links with adult oriented help groups. Rotate personnel whenever possible between Social Services, Justice and Education facilities. This is difficult to do. Formally structured communication does not work, informal does.

The local committee has to decide who is presently responsible for coordinating group agencies. A health centre has to be equipped to do follow-up. Try to create a package operation of paraprofessionals to provide a 24-hour service (weekends and evenings). This is a problem that should be placed on the agenda if a local committee is used.

Problems with transportation in rural areas. Diffuse conflicts between towns and cities. The base has to be a local committee.

Weekend seminars for continuing education to all professionals may be helpful. It may be difficult to make a case for this in a report. To what extent should New Brunswick do its own training and does it take a "maritime role in training"? Collaborate with Atlantic Child Guidance in doing so.

Research & Evaluation - Some research locally. Research in areas considered to be high priorities. Specific information such as an evaluation of emergency services and how such a program is working - list all of these things. We need to form our own opinion of what the priorities are.

CONCLUSION

In making recommendations for Mental Health Services for Children and Adolescents in New Brunswick, the following points made in the Nova Scotia report "Once More for Children" are relevant (some points have been expanded):

1. Structures should be developed to cope with problems that arise. The problems may change but the structures should be in place to handle them. (It may also be necessary to change structures but this should not be done quickly. Attempts to improve existing structures should precede massive organizational change).

2. There are difficulties with the label "mental health". It is not clear to all what services are included under this rubric. (Our emphasis should be providing services to children and their families that promote (increase) healthy adjustment and social competence and treat (decrease) emotional and behavioral problems of individual children/adolescents in a number of environments - home, school and community. It would be helpful to be specific in terms of goals).

3. Priorities for children's services need to be established. Priorities for programs should be research based. Realistic expectations are important; it is not possible financially or because of lack of knowledge to be effective with all problems.

4. Priorities should be established at a local (perhaps regional level) with community input. (At the same time there needs to be coordination across regions to ensure equivalent "quality" services).

5. Structures should ensure that adult and child services do not compete. Where they do, child services lose. *Mental Health Services for Children should be kept physically, budgetarily and programmatically separate from Adult Services where feasible.

6. Some "mental health" services should be combined with general health services. Family practitioners, paediatricians and public health personnel are already involved to a great extent and should be consulted in this process.

7. Some aspects of our service may better be provided through (education) the schools. (Improved services for psycho-educational problems as well as behaviour problems through the schools would be desirable. Greater emphasis should be placed on follow-up and planning rather than assessment of learning processes). (Some aspects of our service are overlapping with Social Services. Again, territories should not be defended. Rather, the services for children need to be specified, the setting for delivery selected and communicated to the public).

8. There needs to be close liaison with several other agencies/departments whatever the structure. There also needs to be liaisons between child and adult services and between community and hospital based services. Processes need to be set up to facilitate coordination rather than competition. (e.g. A plan at the community level (Children's Services Board) for formal arrangements, e.g. cross-appointments, non-attendance at meetings and informal liaisons). Interagency cooperation is possible but takes time and planning. It is helpful to have clearly stated agency responsibilities and be aware of overlapping and unique roles. It is also necessary to have incentives for co-operation - personal and agency rewards.

9. Gaps in the services for children need regular identification.

10. Specific agencies should have responsibility for long-term monitoring of the problem ("the impossible") child or family. Follow-up must be a priority.

11. Monitoring of "high risk" children needs to be a mandated responsibilty.

12. For a small number of children where there is overlap (simultaneous or sequential) in departments, e.g. two or more departments - Justice, Social Services, Mental Health, a coordinating review group needs to be established to ensure continuity and quality services. Education will be involved in all of these cases. There needs to be a <u>means</u> of assigning long term responsibility for these youth. It will take considerable work to develop the necessary policies and procedures.)

13. Most of the services for children are described as primary and secondary prevention. This distinction may not be very meaningful for children. Both health promotion and active treatment programs are necessary and should not compete. Programs that are worthy ends in and of themselves, e.g. parenting courses need not be justified as <u>prevention</u>. Programs that are specifically set up as prevention need to be evaluated.

14. All programs for children require greater <u>evaluation</u>. Program evaluation should be ongoing.

15. Decisions about types of programs should be research based. (Consultants need to provide up-to-date information concerning treatment approaches and programs.)

16. We should recognize that professional rivalries do exist and attempt to encourage complementary rather than competitive behaviour.

17. Services to children need to be provided some evenings and weekends. There needs to be some on-call, 24-hour coverage. (Chimo type phone lines are helpful in this regard with professional back-up.

18. Technology should be used to assist in provision of services Video equipment and teleconferencing by phone or close-circuit TV may be more effective than travel in rural areas. (The primary workers in rural areas (e.g. public health nurses and physicians) need more options for support and professional development. It may be more effective to have the primary worker leave the rural area to visit the consultants rather than vice versa. 19. There need to be options for acute hospital care particularly for adolescents and residential care for a small number that do not respond to community options.

20. (Community options need to be developed prior to closing of residential settings).

21. Some examples of needed services:

-residential treatment

-therapeutic group homes

-therapeutic foster homes

-respite care for handicapped

(also -other resources for handicapped services to preschoolers

-alternative school programs for children with behavioural and emotional problems.

22. Staffing is a problem in both urban and rural areas. There need to be incentives for recruiting as well as maintaining qualified

professionals once recruited. Incentives such as encouragement to meet with colleagues and attend courses, conferences, etc., are cost effective and service effective in the long term.

Continuing education should be a priority for morale and quality services. The perceived lack of encourgement for continuing education and professional development in NB is one of the most frequently expressed concerns of professional staff.

New Brunswick needs to take some responsibility for higher education of professionals rather than depend on other provinces. Coordination in this area with the other Maritime provinces and the Province of Quebec would be an interesting avenue to explore).

23. Data are needed to provide assistance in program planning and evaluation. Data need to be reliable and valid. A uniform system - one easy to use - is needed. Professionals need ongoing training in filling out forms, etc. Individuals who would use the forms need to be involved in their design.

Appendix VI

DEPARTMENT OF PSYCHOLOGY

IWK HOSPITAL FOR CHILDREN

A DESCRIPTION OF SERVICES

prepared by

G. Wayne MacDonald, Ph.D., Director

The Department of Psychology at the I.W.K. Hospital has four functional sub-units reflecting four specific sub-speciality areas.

1) Clinical Neuropsychology Unit
2) Developmental Psychology Unit
3) Clinical Assessment Unit
4) Behaviour Therapy Unit

Psychologists are prepared to address a broad range of behavioural issues which may affect children. This mandate extends beyond traditional Mental Health boundaries to include measurement of behaviour and learning disturbance following brain injury, non-compliance to medical procedures, behaviour management problems in hospital, etc.

At the present time, the Neuropsychology Unit and Behaviour Therapy Unit receive the highest number of referrals and have the largest staff. The Neuropsychology Unit has three full time psychological assistants, one full time neuropsychologist and one part-time neuropsychologist. The behaviour Therapy Unit has three full time psychologists (one on temporary hospital funds). The developmental Psychology Unit and the Clinical Assessment Unit have one full time psychologist per unit.

The services offered through each sub-speciality unit are outlined below.

NEUROPSYCHOLOGY UNIT

Neuropsychology is the branch of psychology concerned with the study of brain behaviour relationships. While all behaviour is related in some way to brain function, neuropsychologists take a special interest in the higher cognitive functions such as perception, language, memory, attention, and so on. All of these functions are important for successful adaptation to the demands of everyday life. The clinical neuropsychologists in this Department are engaged in assessing these functions (generally referred to as adaptive abilities). A more complete description of the actual methods of assessment may be obtained by contacting the Neuropsychology Unit directly.

The children referred to this unit for neuropsychological assessment are a very diverse group in terms of age, health, and development, but they all have in common some form of impaired adaptive functioning. For most children of school age these impairments are reflected in poor school performance, especially skills such as reading, writing, or arithmetic. It is important to point out, however, that deficiencies in other areas such as social behaviour or communication skills may also be present. These and other adaptive deficiencies can be the result of an impairment of brain functioning alone, or in combination with other factors such as sensory or environmental deprivation, emotional or behavioural disturbance, and other types of handicapping conditions.

The neuropsychological assessment is a specialized procedure which is not intended to replace other procedure such as intellectual or psycho-educational assessment. The primary purpose of the neuropsychological assessment is to provide a comprehensive description of a child's abilities and to relate this information to brain function. The information provided by the assessment is usually most helpful in planning remedial or rehabilitational treatment, but the information can also be helpful in determining the etiology of adaptive ability impairments.

Whom to Refer

Referrals for neuropsychological assessment are appropriate in the following circumstances:

1. Where there is known or suspected neuropathology. (e.g. epilepsy, head injury, CNS infections, congenital neuroanatomical malformations).

2. Where there has been a recent dramatic alteration in school performance, personality, or other aspects of adaptive functioning suggesting possible CNS involvement. Very often the etiology of these changes is unclear, and the neuropsychological assessment can be useful as part of a series of investigations.

3. Congenital syndromes. The neuropsychological assessment is often helpful in cases where there is a congenital abnormality associated with physiological or behavioural handicaps. Examples of these conditions are PKU, William's syndrome, Sturge-Weber syndrome, and Turner's syndrome.

In cases where a child exhibits poor academic performance but no evidence of physical handicap or physiological abnormality, a referral should be made for a psychoeducational assessment. For most children in the Atlantic Provinces this type of assessment can be made by the local school psychologist, or a psychologist affiliated with a community mental health centre. Where these services are not available, or when an urgent assessment is needed, a referral should be directed to the Psychoeducational Unit of this Department.

Referrals for neuropsychological assessment should always include the following information when it is available: age and date of birth of the child, a summary of the results of previous psychological assessments, a statement of the presenting problem, and relevant details of the child's medical and developmental histories.

For further information please contact Dr. Wayne MacDonald or Dr. Robert Gates, Neuropsychology Unit, 8th South or phone 424-6055.

DEVELOPMENTAL PSYCHOLOGY UNIT

Developmental Psychology is the branch of science which is concerned with the origin and change in physical, mental and social functioning that occurs throughout the life span.

Whom to Refer

On occasion, a young infant or child does not progress along the expected pathway of development or he/she does not progress at the expected rate of development. These observed changes in either the rate or pattern of developmental progression may be due to either

genetic and/or congenital factors. The aim of the Developmental Psychology Unit at the I.W.K. is to assess the present developmental status of young infants or children who are suspected of exhibiting a slower rate of developmental progression or a pattern of development that is different from what might be expected. The population appropriate for referral to the Developmental Psychology Unit are inpatients, however, a number of appointments are reserved for outpatients who are referred to the Unit by either a physician or a related health care professional.

Upon diagnosis of a significant delay in development and/or an unexpected pattern of development, appropriate referrals may be made to existing health care facilities. In cases where appropriate referral systems are nonexistent, appropriate stimulation activities would be formulated with the aim to reduce the observed delay or change the existing pattern of behaviour.

For further information please contact Dr. Joseph Byrne, 8th Floor South or phone 424-6055.

CLINICAL ASSESSMENT UNIT

At the present time, this unit is responsible for: 1) general psychometric evaluation of children 6-16 years of age; 2) stress management. As there is only one full time psychologist providing this service, it is not possible to offer the complete range of services for which this unit was designed. Sophisticated psycho-educational evaluation and stress management services are offered, whereas personality evalution is not as yet available.

Psychometric Evaluation

The battery of tests administered provides measures of intelligence, achievement (word recognition, spelling, arithmetic), work analysis skills, memory skills and reading ability (including oral and silent reading, recall/comprehension, listening comprehension). Based on the results of the assessment, specific recommendations are made to the school, with the intention that these recommendations be incorporated into the child's academic programme. In a number of cases, special class placements and services are recommended. If it is felt necessary, a referral is also directed to the Neuropsychological and/or Behaviour Therapy units of this department.

Stress Management

Several different stress management programmes or tecniques are utilized in this unit. The three most common techniques are communications skills, personal planning skills and progressive deep muscle relaxation. The approach to be used in any particular case is decided upon after in-depth interviews with the child and relevant others. Where possible, data is collected on a daily basis before, during and after stress management has been initiated. Stress management is usually conducted over a period of six to eight weeks.

Whom to Refer

Children aged 6-16 years who have no known or suspected neurological dysfunction, but may be experiencing some significant problem in adaptation academically, socially, or both.

It is appropriate to refer a child for a psychometric evaluation in cases where:

a) The school which the child is attending does not have the services of a school psychologist and it is not possible for the child to be seen by a psychologist in their local Mental Health Clinic.

b) The child has had an assessment and a second opinion is desired (N.B. In such cases, a re-test interval of at least six months is requested).

It is appropriate to refer a child for stress management in cases where:

a) The child is suffering from chronic pain for which no organic basis has been determined. The majority of referrals falling under this category involve headaches and abdominal pain.

b) The child is exhibiting nervous habits or "tics".

c) The child is experiencing anxiety, whether free-floating or specific. One example of the latter would be a child who becomes extremely anxious during an asthmatic attack.

The above guidelines apply to both inpatients and outpatients.

For further information please contact Maureen Clare MacDonald, M.A., 6th Floor West or phone 424-6056.

BEHAVIOUR THERAPY UNIT

The Behaviour Therapy Clinics located on the sixth floor, west wing (6 West) of the hospital. Behaviour Therapy involves primarily the applications of learning principles to everyday problems. We assume that most of the things people do are learned and that learning principles can be effective in changing what people do. We set specific treatment goals which are intended to expand the parents and/or child's skills and abilities.

Typical areas of service are:

a) Non-compliance to Medical Procedures
b) Eating Disturbances
c) Exceptional Children
d) Pain Management
e) Toilet Training
f) Encopresis
g) Enuresis
h) Social Skills Training
i) Sleep Disturbance Management
j) Stress Management
k) Behaviour Problems in Hospital or at Home
l) Consultation to Hospital Staff and Community Agencies

Whom to Refer

In order to be seen in the Behaviour Therapy Clinic, a patient must be under 16 years of age and referred by a physician. When the Clinic began in 1977, it accepted outpatient referrals. However, due to the increased number of referrals and limited staff time, it has

become necessary to restrict the service and follow-up to families whose children are chronically physically ill or are inpatients at the I.W.K. Hospital for Children.

For further information please contact the Behaviour Therapy Clinic, 6th Floor West or phone 424-6056.

Appendix VII

CHILDREN'S PSYCHIATRIC RESEARCH INSTITUTE

WESTERN

Children's Mental Health Centre for Males & Females

PO Box 2460 Terminal A
London, Ontario
N6A 4G6 (519) 471-2540

Director of Residence:
Mr. R. E. Builder

Age Range: No limit to 18 yrs

Licensed/Approved Capacity of: 141 beds

Documentation Required for Admission:
- Court order
- Social history
- Psychological assessment
- Medical documentation
- Academic documentation

Designated Catchment Area
- Brant County
- Bruce County
- Dufferin County
- Elgin County
- Essex County
- Grey County
- Regional Municipality of Haldimand-Norfolk
- Regional Municipality of Hamilton-Wentworth
- Huron County
- Kent County
- Lambton County
- Middlesex County
- Oxford County
- Perth County
- Regional Municipality of Niagara
- Reg. Municipality of Waterloo
- Wellington County

Referrals from Outside Catchment areas:
- Are accepted

Length of Stay:
- No limit

Residence Professional Staff:

- Child care workers	15 FT	
- Social workers	12 FT	5 PT
- Administrators	4 FT	
- Psychologists	7 FT	
- Psychometrists	4 FT	3 PT
- Psychiatrists	2 FT	
- Doctors (MD's)	10 FT	
- Nurses	16 FT	8 PT
- Recreational Staff	5 FT	

Aftercare Services: Provided

Non-Residential Svcs: Provided
Francophone Services: Provided

Accepts Referrals From:
- Self referrals
- Children's Aid Societies
- Juvenile and family court
- Probation/After-care officers
- Psychiatric facilities
- Training schools
- Psychiatrists/Psychologists
- Schools boards
- Parents or guardians
- General practitioner
- General hospitals
- Other residential settings
- Counselling agencies
- Police
- Clergy

Will Accept Emergency Admission for:
- Court order
- 24 hr stay only
- From police
- Other facilities are full
- Family breakdown

- High risk clients

Primary Goals of the Programs Are:
- Development of academic/vocational skills
- Reintegration of child into own family
- Integration of child into foster family
- Preparation to live independently
- Assisting child to live in a less intensive care environment
- Development of interpersonal relations
- Improved physical functioning
- Development of self-esteem, self-awareness and self-control
- Improvement of speech or language
- Assist child to mature in safe setting
- Improved functioning of child within acceptable community boundaries
- Protection of the community

Types of Assessments:
- Community
- Psychological
- Social
- Medical (Physical)
- Recreational
- Academic
- Behavioural
- Family

Guardianship Status Accepted:
- Independent
- CAS/CCAS temporary ward
- Crown ward
- Training school ward
- Parental control
- CAS/CCAS non-ward agreement

Physical Setting Is: Residential

Will Not Accept Children With The Following Conditions, Problems, or Behavior Patterns:
- All conditions accepted

Appendix VIII

The Department of Health is concerned about the adequacy of mental health services for children and adolescents in the province of New Brunswick. To address this concern, a Planning Committee on Mental Health Services for Children and Adolescents was established. The committee is composed of members from the Departments of Education, Social Services and Justice representing the fields of psychiatry, psychology, social work, nursing, education, criminology and administration.

The terms of reference for this committee are attached for your information.

The committee would like information from other organizations concerned with this subject. If your organization is interested in contributing to this committee, we welcome any written suggestions, recommendations and/or briefs. We would appreciate receiving your submission prior to January 1, 1984.

We are looking forward to hearing from you in the near future.

Sincerely,

Maurice Boulay, Psy.D., F.C.P.A.
Chairperson
Planning Committee on Mental Health
Services for Children and Adolescents

Enclosure

Appendix XI

CONSULTATION WITH AGENCIES

Because of the relatively short period of time for this committee to do its work, it was decided to write to a number of organizations to obtain their input. Consequently, we wrote to twenty-seven agencies and institutions making them aware of this committee's work. Seven organizations replied to our request with five of them making specific recommendations which are as follows:

Mental Health-New Brunswick

Nancy Rideout

Chairperson

Program Advisory Committee

The recent announcement pertaining to the William F. Roberts School has additional implications for services to emotionally disturbed children and we believe that the work and recommendations of your committee will be timely.

The following points are put forward by our committee for your review and consideration:

1. We strongly support the idea of prevention and early identification of children with behaviour, emotional or learning disabilities. We can anticipate who the at-risk-groups are (young parents, single parents, unemployed), and additional emphasis and resources should be available at the elementary school level.

2. There is a need for centralized responsibility for agencies working with children with emotional/behavioural difficulties. At the present time, services to children are fragmented between the Departments of Health, Education, Justice and Social Services. There is a need for a more coordinated and integrated approach.

3. Resources for training people within services for children are important. There is a need to bring together agencies involved in children's services to promote training and professional development.

4. There should be a holistic approach to the treatment of children rather than different agencies or disciplines being concerned with only one aspect of a child's needs.

5. Approaches to services should be centered on the child. Efforts to work with children should focus on the family setting. This requires additional support to families and parents in the community to enable them to cope with children with disabilities.

6. There should be in place minimal standards for education throughout the province. Specific helping resources should be available to schools throughout New Brunswick.

7. Support to children should emphasize an interdisciplinary model which would combine the expertise of all resources available to work with children with emotional/behavioural/ learning problems.

8. At the junior high and high school level we are concerned about the decline in support services (guidance and counselling) at a time when they are needed more than ever.

I hope that our comments will help your committee in their deliberations and subsequent recommendations.

CANADIAN ASSOCIATION FOR THE MENTALLY RETARDED
NEW BRUNSWICK DIVISION

Lorraine Silliphant

Thank you for your letter of November 23. As I indicated by phone, we are unable to respond to your request in the manner we would wish or that is complete.

We agree wholeheartedly with the principles outlined in your document. We would add that services be child centered and that the goal of any service be to help the child function as independently as possible in his home community.

As you are aware, all children who are served under the Auxiliary Classes Act must be referred by a Mental Health Clinic in their area. Our association realizes that if this role is to continue certain things must be in place:

1) staff must have adequate training, experience and understanding of people with mental retardation,

2) children must have complete interdisciplinary assessment and diagnostic services which are child focused and program related,

3) someone must be responsible for the management of an individualized plan to meet the child's needs,

4) staff must have good liaison with, and knowledge of educational programs for the children,

5) reassessment capabilities which will indicate progress and appropriateness of programs are needed,

6) knowledge and awareness of the importance of early intervention programs are necessary so that correct referrals can be made at an early age and that programs can be developed,

7) appropriate university and inservice training for professional staff is necessary,

8) back-up support to families, foster homes, and educational programs needs to be made available.

9) provision of consultation in behaviour training and crisis intervention for children with behaviour problems is necessary.

The major problem facing community health and social services today is that they need to be child centered in order to solve problems for that child. Appropriate support services need to be available for the child and the family. There must be a change from a system which uses a "medical" model to a "social development" model for children who have mental retardation.

In a recognized child focused system, staff must move out of the "clinic" to observe children and help them where they learn and live.

Hospital services such as physiotherapy, speech and occupational therapy are important to us as is their availability within a system which addresses the whole child and is client focused. However, there is no role for Nursing Homes in the lives of mentally retarded people.

Nursing Homes are for people 65 years of age or older. As well, services ought to be in the least restrictive setting possible.

As CAMR moves away from providing educational programs, it will be expanding its advisory role. It is possible for us to be developing new programs such as early intervention, self-advocacy, leisure, parent-to-parent and extended family. However, professional and voluntary agencies will need to work together for these to be successful.

I realize that this response is not well documented or developed. If you have any questions, please feel free to call me at the above address.

Thank you for this opportunity to have input into this important area.

THE NEW BRUNSWICK TEACHER'S ASSOCIATION

Jack MacKinnon, Executive Director

Introduction

The New Brunswick Teachers' Association appreciates the opportunity to make a submission to the Planning Committee on Mental Health Services for Children and Adolescents. Our association, for some time, has been aware of lack of services for this group of our student population and commends the Department of Health for its review in the hope that improved services will be forthcoming.

Present Situation

The New Brunswick Teachers' Association recognizes that mental health services for children and adolescents is only one type of service to this particular student group and many of the concerns addressed here are part of an overall concern for adequate services for the entire student population. Many of the issues discussed here could be repeated in discussions on other services to the general student population.

a) Intregration of Services - The Departments of Health, Education, Social Services and Justice, each has some responsibility in providing services to children and adolescents; however, each has worked too much in isolation. The result has been a duplication of services, confusion therein, and a jealous guarding of jurisdictional responsibilities. One of the key concerns of NBTA is that an integrated approach should be taken to provide services for all students so that a sharing of resources might result in improved services. At present, the services are poorly coordinated or duplicated. This duplication of services compounds a problem of resources and considerable attention must be given to the sharing of these resources so that there will not be the tremendous variability in services available that presently exists.

b) Target Population - Another key concern of the New Brunswick Teachers' Association is the legal limitations of many of the present Acts; for example, the Schools' Act provides education services for adolescents to age sixteen. The Juvenile

Delinquency Act and the Child and Family Services and Family Relations Act apply to adolescents to age sixteen. The proposed Young Offenders Act applies to adolescents to age eighteen. The present Auxiliary Classes Act reaches to age twenty-one. There do not appear to be any jurisdictional rights under some of these Acts for the age span for sixteen and seventeen year olds. They are neither adults, nor classed as children or adolscents. It is essential that a model for a provincial service for children be established and that it include the age group sixteen and seventeen year olds. The Planning Committee on Mental Health Services for Children and Adolescents is looking at the target population up to age nineteen, who suffer from mental disorders or are at risk. Again, there needs to be a specific age span applicable under all Acts, so that there would not be overlap of service or lack of jurisdictional responsibility.

c) Educational Services - Although the Schools' Act provides that educational services must be available to students, there seems to be no legislative mandate that the child with "special needs" has to be educated within the guide-guidelines prescribed by the provincial curriculum. For those students in "special" situations, in particular, students at the William F. Roberts School and at the Kingsclear Training Centre, it is essential that they follow the curriculum as outlined for the public school system. The educational services must be standard for the province, and no matter where the student is placed in order to have his or her special needs addressed, the educational needs must be met through the provincially prescribed curriculum or through materials that parallel the goals of the curriculum.

d) Equalization of Services - Services in rural areas of the province are not as accessible as in urban areas. Outreach services tend to serve the community first and are not school based. In other words, the waiting lists in such cases are such that students requiring special assistance are placed on a waiting list.

Early intervention is of paramount importance when serious mental health problems are suspected. The same applies when other problems arise for students. The expanding caseload and decreasing time available to deal with clients may result in serious problems as a result of delay. In some areas of the province, the problem is not access to service, rather that each jurisdiction (Health, Education, Justice, Social Services) takes its turn and the child is moved from team to team as each tries to solve the problem at hand. In many instances, the mental health problem is only one of several problems the child or adolescent may have and hence, an integrated approach is more helpful. One of the problems seems to be that no one wants to give up his territory but each in isolation is too unfamiliar with the responsibilities and conerns existing in another Department. There needs to be a comprehensive and integrated approach to providing services to children and adolescents. The lack of funding existing in one Department seems to be available in another. If there were a structured and integrated approach, the same services could be offered in all areas of the province. In a time of restraint, duplication of services is deplorable.

e) Information Sharing - Earlier reference is made to the lack of coordination between departments. Employees in one department may have little knowledge of the school system or the approaches used for assessment, and often information cannot be easily communicated from one department to another. If the services were coordinated through one department, then the sharing of information would be standard procedure; hence, duplication of assessments and lack of information would not result in delays in attempts for rehabilitation or treatment.

f) Resources - Teachers have always provided a special service in the identification of students with special needs. Tremendous strides have been made in diagnosis. Yet, identification and diagnosis are useful only if a remediation service is available and this is one area of service that is lacking in the areas of mental health and the behaviourally/emotionally disturbed. Again, the sharing of resources could help with some of the much needed solution to this problem.

g) Referrals - The societal structure of the day places more children and adolescents under stress than in years past; hence, there are greater numbers in the system requiring special services. The expanding caseload and the decreasing time available to deal with students with special problems is resulting in critical delays and costly consequences. While services in the rural areas of the province are not as accessible as in urban areas, teachers are called upon to deal with like situations whether they teach in rural or urban centres. Parents are more likely to seek help if the services were provided within

the school system. Some are reticent to come forward because of the stigma of a "mental health" problem. Many of the specialized services required for dealing with the problems of the day are not presently available. For example, crisis intervention services for potential suicides among adolescents is one area that is extremely lacking in our province. Drug and alcohol rehabilitation for families with these problems again requires special attention. Presently, agencies providing programs for adolescents with drug and alcohol problems do so on an ad hoc basis. Another area of concern is referral to the system rather than to a specific agency. There seems to be no direct contact with the agents in the other agencies when a referral is handled; in other words, communication is a problem. Further, the teacher referee is not usually involved when the referral is carried out. There is little communication between schools and the mental health clinics. Teachers would find it helpful in dealing with students if they were aware that students were under treatment or had been treated. Indeed, the teacher might be an important resource to enlist in the treatment program.

Another specific concern within the referral system is offered by the William F. Roberts School in Saint John.

This institution may be closed. Within the public school system there is only one class (six students) in the province for the emotionally/behaviourally disordered. Some students need to be placed in a residential facility for assessment and/or treatment. There are better therapeutic support services in such a setup.

In many cases, if the facility was more community or regionally based, long term placement in the institution would be unnecessary. While some students need to be placed in a 24-hour, controlled environment for short term treatment, others would benefit from a day program.

If the William F. Roberts School is to be closed, it must be replaced by <u>something</u>. Our recommendation is that there be regional centres set up to provide for residential assessment, and treatment when necessary. If regional centres were in place and available to all school districts, then the combined resources of psychologists, psychiatrists, social workers, nurses, teachers, etc., could be offered in a setting that would allow for gradual integration and return to a normal lifestyle for the student. The regional service in such a centre could then be integrated with the local services available so that every kind of behaviour and emotional problem could be handled as part of the public school system.

h) <u>Guidance Services</u> - In the province of New Brunswick, guidance services for students have been limited mainly to senior high level and at that level, career guidance and course selection have been the priority. Teaching loads have been increasing at a time when there is a growing need for counselling students in situations beyond the teaching function. It is important that comprehensive guidance services be provided at all grade levels so that the day-to-day problems can be dealt with. Students who suffer from emotional/behavioural disorders need a great deal of attention, and often more than the regular classroom teacher can

give. If there were adequate support services available, then more students may be able to function within the public school system rather than be placed in an institution at a time when a crisis arises. Perhaps the crisis would not arise if earlier attention were given to the child's need. For example, a case is cited where four children from a family were moved back and forth between the parents several times in two years. To be more specific, a child ten years old had been in thirteen different schools. Another child in grade two had been in nineteen schools in eighteen months. Such moves, compounded by family conflict, resulted in emotional problems for the children involved. Surely, if departments worked together a solution could be found long before a situation reached such critical proportions. Adequate support and guidance for both the students and the parents would have meant a much earlier resolution to this problem.

i) Follow-up - In only a very few circumstances in which treatment is provided for students with emotional/behavioural needs, would there not be a need for continuing attention. Children change as they grow and the services offered in a residential setting may not be nearly as accessible when the child is placed in a public school setting. In addition, the caseloads of the social workers, the teachers, and others involved in the treatment are often so heavy that once the child has initial treatment, he or she receives no special attention until a problem arises again. The road to recovery is slow and often leads to regression. The Planning Committee on Mental Health Services for Children and

Adolescents is encouraged to give special attention to adequate resources to allow for follow-up of all students treated for mental or emotional disorders.

Conclusion

This submission has attemped to address the present situation with respect to services provided in the province of New Brunswick for children and adolescents who suffer from emotional/behavioural disorders or are at risk. Specific issues have been identified with respect to existing legislation affecting the care of children and adolescents, the need for staff resources and the lack of home and community based services. Again, it is emphasized that all children and adolescents should be followed through the system to ensure that treatment and support needs are met whether the service is mental health treatment or remedial assistance or some other specific treatment to meet a child's needs. It is important that a total program be in place and the association supports the establishment of regional centres so that most students may be provided services in the least restrictive environment and as close as possible to the child's or adolescent's home. The association commends the Department of Health for this study and looks forward to the opportunity for further input once the study has been completed by the Department of Health.

Recommendations

1. That mental health services to children and adolescents be coordinated through one agency.

2. That regional centres be established throughout the province to provide and coordinate services to all school districts for assessment, diagnoses, and treatment of children and adolescents with special needs.

3. That a comprehensive and integrated approach be established when studying provision of services to children and adolescents by the Departments of Education, Health, Justice and Social Services.

4. That current legislation affecting the care and protection of children and adolescents be reviewed so as to ensure the availability of these services for sixteen and seventeen year olds.

5. That adequate resources be provided for follow-up services for children and adolescents treated for emotional/behavioural disorders.

CANADIAN REHABILITATION COUNCIL FOR THE DISABLED
NEW BRUNSWICK BRANCH INC.
June E. Hooper, Executive Director

Thank you for your letter of November 16, requesting input to your committee on the need for mental health services for children and adolescents in New Brunswick.

CRDC is established to provide rehabilitation equipment and financial assistance to access rehab services for children and adults. We also operate the Rotary Camp for disabled persons on a seasonal basis. We are not well qualified to comment on the issues concerning

your committee.

We are, however, aware of the lack of mental health support services to disabled children and adolescents. The clients we serve have fragmented health services in the area of physical rehabilitation. This presents pressures to the family and disabled individuals which cause problems of psychological and social adjustment.

We suggest the committee examine the mental health services available to disabled children and adolescents in conjunction with physical rehabilitation programs and public and "special school" programs. Perhaps this could best be done by involving a rehabilitation specialist on the planning committee. Marilyn Smith, Psychologist at Forest Hill Rehab Centre, could be an excellent resource person to your committee.

If there is any way we can be of further assistance, please contact us at your convenience.

SCHOOL OF NUTRITION AND FAMILY STUDIES
UNIVERSITE DE MONCTON
Marielle Prefontaine, PH.D.

The following comments are submitted subsequent to your letter dated November 16, 1984.

1. The mandate for your committee does not seem to be complete. In my opinion, mental health does not only involve prevention and

treatment of "emotional disorders", it implies also the aid we can provide to the youth in order to permit them to develop the skills necessary to cope with emotional problems. The number of children and adolescents who suffer from emotional problems is increasing; this number is greater than those that suffer from emotional disorders. Therefore, the committee on mental health services should keep this in mind in their deliberations by including this group in their target population.

2. In terms of principles, should you not add to your list that mental health services should contribute towards enlarging the youth's natural network which is often too self-centered. I am thinking in particular of placing value on the ability of ordinary people to help the youth who suffer from emotional problems. Ordinary people are capable of helping youth face a crisis, to help in the manner in which they should react to those close to them experiencing a crisis.

3. The model which you have chosen to plan mental health services appears to be a socio-developmental or ecological model. This is reflected in the specific objectives on page 3. If you work with this model, instead of thinking about prevention, you will have to think in terms of the promotion of the individual and the group. Prevention means preventing deterioration, this can be done without really having to change the environment. Promotion means encouraging development, making a concerted effort, defended and supported by social change and encouragement of the potential for human growth. In putting forward an ecological model to reorganize mental health services, it will be necessary

for hospitals to concede to centres for social intervention and that the change agents learn to lobby government and those responsible for program development, that they propose new avenues, that they get closer to pressure and self-help groups, etc. Certainly, it is not sufficient to modify environments to do promotion but to respect the interactive nature of the individual's relationship with his/her environment.

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